TEXAS
Health and Human
Services

Prior Authorization in Managed Care

August XX, 2020

State and Federal Prior Authorization Requirements

- 42 U.S.C. § 1396r-8
- Texas Government Code §531.073
- Texas Government Code §533.005(a)(23)
- Texas Human Resources Code §32.073
- Texas Insurance Code §1217.004
- Texas Insurance Code §1369.256

TEXAS
Health and Human Services

Managed Care Organization Requirements

- The managed care organization's (MCO's) utilization management (UM) program must include written policies and procedures to ensure:
  - Consistent application of review criteria that are compatible with members' needs and situations;
  - Determinations to deny or limit services are made by physicians under the direction of the medical director;
  - At the MCO's discretion, pharmacy prior authorization determinations may be made by pharmacists
  - The prior authorization process does not result in undue delays in services

TEXAS
Health and Human Services

Managed Care Organization Oversight (1 of 2)

- HHSC shall monitor the MCO to confirm the MCO is using prior authorization and utilization review processes that ensure appropriate utilization and prevent overutilization or underutilization of services.
- The MCO must have a process in place to monitor a member's claims history for acute and long-term care services that receive a prior authorization to ensure that these services are being delivered.

TEXAS
Health and Human Services

Managed Care Organization Oversight (2 of 2)

- On an ongoing basis, the MCO must monitor claims data for all approved prior authorizations for delivery of the services.
- The MCO must research and resolve any services not received as a result of the lack of claims data.

TEXAS
Health and Human Services

Other Requirements (1 of 2)

- The MCO must provide a provider portal that supports functionality to reduce administrative burden on network providers at no cost to the providers.
- The provider portal functionality must include prior authorization requests.
- MCOs must give providers 30 days' notice before implementing changes to policies and procedures affecting the prior authorization process, except in cases of suspected fraud, waste, and abuse.

TEXAS
Health and Human Services

Other Requirements (2 of 2)

- The MCO must have a continuity of member care emergency response plan based on a risk assessment for each of the service areas in which services are provided under the contract, using an "all hazards" approach to respond.
- As part of the plan, the MCO must describe the method it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by HHSC, and the method by which the MCO will identify the location of members who have been displaced.

TEXAS
Health and Human Services

Prohibited Prior Authorization

(1 of 2)

- Court-ordered services
- Emergency services
- Emergency medical condition
- Emergency behavioral health condition
- Emergency detention
- Labor and delivery
- Family planning
- STD services and HIV testing services
- School-based telemedicine services

TEXAS
Health and Human Services

Required Prior Authorization

(2 of 2)

- All PPECC services must be prior authorized.
  - All prior authorization requests must contain documentation of medical necessity including a physician order and PPECC plan of care.

TEXAS
Health and Human Services

Continuity of Care (1 of 2)

An MCO is required to ensure continuity of care when a member enrolls in managed care or changes MCO.

- If the member already has a prior authorization, he or she must receive continued authorization for:
  - 90 days after the transition to a new MCO
  - Until the end of the current authorization period, or
  - Until the MCO has evaluated and assessed the member and issued or denied a new authorization.

TEXAS
Health and Human Services

Continuity of Care (2 of 2)

An MCO is required to ensure continuity of care when a member enrolls in managed care or changes MCO.

- If the member was receiving a service that did not require prior authorization but does under the new MCO, he or she must receive continued authorization for:
  - 90 days after the transition to a new MCO, or
  - Until the MCO has evaluated and assessed the member and issued or denied a new authorization.

TEXAS
Health and Human Services

Pharmacy Prior Authorization (1 of 2)

- Medicaid drugs may be subject to clinical prior authorization, non-preferred prior authorization, or both.
  - **Non-Preferred Prior Authorization:** Drugs identified as non-preferred on the Medicaid Preferred Drug List require prior authorization.
  - **Clinical Prior Authorization:** Clinical prior authorizations are based on evidence-based clinical criteria and nationally recognized peer-reviewed information.
    - A clinical prior authorization may be optional or required.

TEXAS
Health and Human Services

Pharmacy Prior Authorization (2 of 2)

- If the MCO cannot respond to a prior authorization request within 24 hours, or if it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation, the MCO must allow the pharmacy to dispense a 72-hour supply of the drug.

TEXAS
Health and Human Services

Dental Prior Authorization (1 of 2)

- If a member is new to a DMO and has an open prior authorization, the DMO must accept that prior authorization and cannot require additional authorization or review.
- All orthodontic services must be prior authorized.
- The MCO is responsible for prior authorizing medical services necessary for the administration of general anesthesia for dental services requiring level IV sedation.

TEXAS
Health and Human Services

Dental Prior Authorization (2 of 2)

- CHIP services above the annual cost limit must be prior authorized and only approved if the service is:
  - Diagnostic or preventive; or
  - Necessary for the member to return to normal, pain and infection-free oral functioning.

TEXAS
Health and Human Services

TEXAS
Health and Human
Services

Questions?